Editorial

Dilemma of High-Tech Care for High-Risk Patients

A PATIENT WITH alcoholism will die if a second liver transplantation is not done. An injection-drug user with a destroyed aortic valve urgently needs a prosthetic replacement. A three-pack-a-day cigarette smoker requires another angioplasty. All these patients have one thing in common—they lead high-risk lives, and they require expensive health care.

With health care expenditures in the United States moving well into a double-digit percentage of the gross national product, and with major efforts being made by the Clinton Administration to reform health care so that everyone will have basic coverage, the use of expensive technology to care for patients leading high-risk lives is becoming a real concern. Many feel that these patients do not deserve such care, while others argue that health benefits have to be equal for all.

To physicians involved in managed care who find themselves stringently overseeing the practice patterns of their colleagues to curb expenses, a patient with alcoholism who needs a liver transplant represents, in effect, "an enemy of the people." Such a patient is often perceived by physicians as an irresponsible person whose wayward lifestyle is using up medical resources that could be more satisfactorily directed toward preventive medicine, for example. Physicians therefore feel a great deal of ambivalence in using expensive therapy for such high-risk patients. For some physicians, the situation becomes so untenable that they find ways of dumping these patients into the laps of colleagues who are less judgmental.

At first glance, the concept of not rewarding "bad" behavior with medical salvation seems logical. Those who initiate trouble for themselves, like suicidal persons who shoot themselves into a morbid but not lethal vegetative state, do not appear to be "worthy" of expensive, life-prolonging care. The same might be said of injection-drug users with repeated episodes of bacterial endocarditis that totally destroyed their mitral valves. But before physicians rush to judgment and withhold care from ill-behaved persons, they should consider the busy executive who forgets to take prescribed prophylactic medicines for rheumatic heart disease, and serious sequelae develop. Or what about the bold mushroom hunters who consume the fruit of their search and have their liver destroyed by toxic mushrooms? Are they to be denied high-tech care because of their behavior? Most physicians probably would not deal harshly with them because anyone can make a mistake. Yet, persons with alcoholism or those who use illicit drugs are in trouble because they made mistakes in their choice of substances to abuse.

There are anecdotes about physicians who refuse to perform coronary artery bypass procedures on heavy smokers who will not quit their habit. Some physicians have policies that they will not care for anyone who smokes. They argue that their withholding of medical services will stimulate patients to change their bad behavior into good, thus helping to ensure better medical results for these patients. Are they adopting this approach to punish noncompliant patients?

The ethical behavior of physicians is not codified, but generally can be distilled into "First, do no harm" and "Offer whatever is needed to benefit the patient." Arbitrarily excluding patients from appropriate care because of their lifestyle is probably not concordant with the Hippocratic Oath. Yet arguments can be made that modern science and technology have put such extraordinary burdens on society's resources that the oath is no longer relevant and factors like inappropriate behavior or noncompliance have to be considered.

As each new scientific breakthrough raises the expectations of society, the possibility that patients will clamor for and receive these new therapeutic modalities is likely. That these might then be sought for high-risk persons is also possible. Because almost all new procedures and pharmacologic agents tend to be more expensive than those they supersede, making them available to all could increase the costs of health care enormously.

So far there is no "health czar" to say no when demands for new scientific achievements are made. There are, however, individual physicians who can appreciate the futility of offering expensive new treatments to patients who will not be compliant, and these physicians will say no. Others will simply go along and provide care that is doomed to failure. It could be argued that because the government often is "the payer of last resort," the government should be denying care to high-risk patients. But government is accountable to society, and it is finally society that determines whether high-risk patients deserve high-tech care.

With the tightening of health care resources, medicine, government, and society will have to accept the necessity of making unpleasant decisions, particularly those regarding the withholding of treatment from high-risk patients. Physicians will not relish being in the highly visible front lines and making draconian decisions, and they will probably cast about for others to do this unpleasant work for them. But technology grows more sophisticated each day, and each day the need to choose the appropriate algorithm for the care of high-risk patients grows more critical. None of us can hide from this reality.

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